# **IDAHO RYAN WHITE MEDICAL CASE MANAGEMENT ASSESSMENT**

Relati	ion to Annlicant									
	Name Relation to Applicant Date of Birth Gender									
/										
		/	Male	Female						
		/	Male	Female						
		/	Male	Female						
			Male	Female						
		/	Male	Female						
			Male	Female						
MONTH	ILY HOUSEHOLD	/ FAMILY GROSS INCOME								
Applicant	Household	Source	Applicant	Household						
\$	\$	TANF/TAFI	\$	\$						
\$	\$	Food Stamps	\$	\$						
\$	\$	WIC	\$	\$						
\$	\$	Alimony	\$	\$						
\$	\$	Child Support	\$	\$						
	\$	Enhanced Rent	\$	\$						
		Energy Assistance	-	\$						
\$	\$	Total Income	\$	\$						
MON	NTHIV HOUSEHO	NID / FAMILY FYDENSES								
	1		Applicant	Household						
• • •		Medical		\$						
		Clothing		\$						
	\$	Telephone	\$	\$						
\$	\$	Cable	\$	\$						
\$	\$	Credit Card(s)	\$	\$						
\$	\$	Entertainment	\$	\$						
\$	\$	Miscellaneous / Other:	\$	\$						
\$	\$	Total Expenses	\$	\$						
	Applicant \$ \$ \$ \$ \$ \$ \$ \$ \$  MOI Applicant \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	Applicant         Household           \$         \$           \$         \$           \$         \$           \$         \$           \$         \$           \$         \$           MONTHLY HOUSEHOUSEHOUSEHOUSEHOUSEHOUSEHOUSEHOUSE	\$ \$ Food Stamps \$ \$ WIC \$ \$ \$ Alimony \$ \$ \$ Child Support \$ \$ Enhanced Rent \$ \$ Energy Assistance \$ * Total Income   MONTHLY HOUSEHOLD / FAMILY EXPENSES  Applicant Household Source \$ \$ Clothing \$ \$ \$ Clothing \$ \$ Telephone \$ \$ \$ Cable \$ \$ \$ Credit Card(s) \$ Entertainment \$ \$ Miscellaneous / Other:							

PRIVATE INSURANCE									
Client eligible for	□NO	If VEC is allow.		INO If NO	D, why?				
insurance?	□YES	If YES, is client	enrolled?	IYES					
Maximum yearly or	r lifetime	Does your insu	rance cover $\  \  \  \  \  \  \  \  \  \  \  \  \ $	NO Ded	uctible:		Medica	ation co-pays	: \$
benefits:		medications?		IYES					
Medical visit co-pay	ys: \$	Comments:							
			MEDIC	ARE					
Medicare:	□NO □YES	If Yes, Effective	e Date:/	/					
If No, eligible?	□NO □YES	Medicare Cove	erage: □ Part	A 🗆	Part B	□ Part C	2	□ Part D	
Client eligible	□NO □YES	Comments:							
for IDAGAP?									
			MEDIC						
Medicaid:	□NO □YES	If yes, effective	e date:/	/	_				
ii ite, engister	□NO □YES	Case Worker:			Te	elephone #:	(	) -	
Comments:									
A	16 66		HITE PARTS B & C P				T-1	l U.	
Applied □NO for	If yes, effect		eligible? □NO	Medical Cas	se iviariag	er:	reiep	hone #:	
RWPB: □YES	/	/	□YES				(	) -	
Applied	If yes, effect	ive date:		Medical Cas	se Manag	er:	Telep	hone #:	
for	, ,		eligible? □NO		J		,	`	
RWPC: □YES	/	/	□YES				(	) -	
Utilizes ADAP for H	IV □NO	Comments:							
Medications?	□YES								
Which of the follow	wing Ryan Whi	te services would	d benefit you?						
☐ Medical Case	Management	□ Mental I	Health Services	□ De	ntal Care	□ Inter	preter a	nd Translatio	n Services
□ Outpatient Me	edical Care	☐ Short-Te	erm Emergency Assi	stance	п Ті	ransportation	to Medi	cal Appointm	nents
-	ment (non-med	<u> </u>	eferral for Health Ca		l .	<u> </u>		cal Nutrition :	
		·		e and Suppo	TUVE SELV	ices 🗆	ivicuit	cai Nutrition .	JEI VICES
If available, would	_	om any of the fo	llowing services?				1		
Help with you insurance cost		☐ Home Heal	th Care 🛭 🗆 H	ome & Comm	nunity Bas	sed Health	□ ⊦	lospice Care	
☐ (Outpatient) S Abuse Service		Child care of program m	during medical & eetings	1 1 1	d Bank / H vered Me			esidential Su Abuse	bstance
Health Educat	ion / Risk	Housing	Legal Service	es for Access		Outreach Se	rvices	□ Respi	ite Care
Reduction	<u> </u>	Services	to Eligible B	ı			1 .		1.
Permanency P for Minor Chil	- 1 -	Psychosocial Support	Rehabilitati Services		bstance A rvices (res			dherence Co non-medical	_
Comments:									
			HOP	WA					
Currently receiving	□no If	no, □NO	If yes, application	date:		Services: □	STMRU	□ Mental	Health
HOPWA?		igible? □YES		/	-				
Comments:	•								

2. SAMISS <sup>1</sup>	<sup>1</sup> (Substance Abuse and Mental Illness Symptom	s Screener)
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SUE	STANCE ABUS	E ITEMS						SC	ORE
1.	drink of hard li	iquor, or	wine cooler. Each of to ou do not drink, go to	hese counts as one			ude one beer, one glass of v nless they have double shots		
	0 1 2	[ ] [ ]	Never Monthly or less 2-4 times a month	3 4	[	]	2-3 times a week 4 or more times a week		
2.	How many dri	nks do y	ou have on a typical da	ay when you are d	rinki	ng?			
3.	0 1 2	[ ] [ ]	1 or 2 3 or 4 5 or 6 e four or more drinks o	3 4	[	]	7 to 9 10 or more		
	0 1 2	[ ] [ ]	Never Monthly or less 2-4 times a month	3 4	]	]	2-3 times a week 4 or more times a week		_
Sur	n of response:	s for Qu	iestions 1 -3:					[	]
4.	In the past yea	ar, how o	often did you use nonp	rescription drugs	to ge	t hig	h to change the way you fe	el?	
	0 1 2	[ ] [ ]	Never Monthly or less 2-4 times a month	3 4	[ [	]	2-3 times a week 4 or more times a week		
5.	In the past year you feel?	ar, how o	often did you use drugs	s prescribed to yo	u or t	:0 so	meone else to get high or cl	nange the	e way
	0 1 2	[ ] [ ]	Never Monthly or less 2-4 times a month	3 4	[ [	]	2-3 times a week 4 or more times a week		
Sur	n of response:	s for Qu	estions 4 -5:					[	]
6.	In the last year	r, how o	ften did you drink or u	se drugs more tha	an yo	u me	ant to?		
	0 1 2	[ ] [ ]	Never Monthly or less 2-4 times a month	3 4	[ [	]	2-3 times a week 4 or more times a week		
7.	been able to?	you fee	I you wanted or neede	d to cut down on	your	drin	king or drug use in the last y	ear, and	not
	0 1 2	[ ] [ ]	Never Monthly or less 2-4 times a month	3 4	[	]	2-3 times a week 4 or more times a week		
Sur	n of response:	s for Qu	estions 6 -7:					[	]
a) 1	The <b>sum</b> of res	sponses	for Questions 1-3 is for Questions 4-5 is	≥ 5	if <u>an</u>	<u>v</u> of	the following criteria are	met:	

c) The sum of responses for Questions 6-7 is  $\geq 1$ 

<sup>&</sup>lt;sup>1</sup> Whetten, K., Reif, S., Swartz, M., Stevens, R., Ostermann, J., Hanisch, L., Eron, J.J. (2005). A brief mental health and substance abuse screener for persons with HIV. *AIDS Patient Care and STDs 19*(2), 89-99.

#### **MENTAL HEALTH ITEMS:**

### Medications/antidepressants

- 8. During the past 12 months, were you ever on medication/antidepressants for depression or nerve problems?
  - 1. YES
  - 2. NO

### **Major depression**

- **9.** During the past 12 months, was there ever a time when you felt sad, blue, or depressed for two weeks or more in a row?
  - 1. YES
  - 2. NO
- **10.** During the past 12 months, was there ever a time lasting 2 weeks or more when you lost interest in most things like hobbies, work, or activities that usually give you pleasure?
  - YES
  - 2. NO

#### Generalized anxiety disorders

- **11.** During the past 12 months, did you ever have a period lasting 1 month or longer when most of the time you felt worried and anxious?
  - 1. YES
  - 2. NO

### Panic disorder

- **12.** During the past 12 months, did you have a spell or an attack when all of a sudden you felt frightened, anxious, or very uneasy when most people would not be afraid or anxious?
  - 1. YES
  - 2. NO
- **13.** During the past 12 months, did you ever have a spell or an attack when for no reason your heart suddenly started to race, you felt faint, or you couldn't catch your breath? (If respondent volunteers "only when having a heart attack or due to physical causes," mark "NO")
  - 1. YES
  - 2. NO

Patient considered positive for symptoms of mental illness if he/she responded yes to any mental health question.

## 3. HOMELESS PREVENTION SCREENING TOOL<sup>2</sup>

• .	ility of your housing situation. These questions can help to determine to each question honestly. You are not required to answer any of the						
questions.	each question honestry. For are not required to answer any or the						
Gender:   Male Female							
1. Are you homeless right now? (If answered NO, skip to que	estion #2) NO YES						
	Weeks: Months: Years:						
b. Which shelter are you staying at today?							
2. Do you have difficulty meeting your food, rent, utility an	d/or transportation needs? □ NO □ YES						
3. Do you have housing problems? □ NO □ YES If y	ves, what are they?						
$\hfill\Box$ Legal eviction notice within the past 30 days	☐ Doubled up with family or friends						
☐ Did not pay last month's rent	☐ Overcrowded living situations						
☐ Did not pay utility bill(s)	☐ Threats of being kicked out						
☐ Building in bad condition (Windows, locks, plumbing,	□ Other:						
insects, rodents, hot/cold water, electricity, etc)							
4. In the past 30 days (or 30 days prior to hospitalization / $\ensuremath{\text{i}}$							
☐ Owned apartment, room or house	Number of Days:						
☐ Rented apartment, room or house	Number of Days:						
☐ Family of friend's home / apartment	Number of Days:						
□ Shelter	Number of Days:						
☐ Hotel or SRO	Number of Days:						
☐ Abandoned building, park, train station, car, streets	Number of Days:						
☐ Institution (hospital, halfway house, nursing home)	Number of Days:						
☐ Foster home or group home	Number of Days:						
$\square$ Jail, prison or detention center	Number of Days:						
□ Other:	Number of Days:						
5. Have you ever been homeless as an adult? $\hfill \square$ NO	□ YES						
<ul><li>a. How many times have you been homeless in your life</li><li>b. In what year(s) were you homeless?</li></ul>	?						
<ul> <li>c. What was the longest period of time you were homeless? (including shelter days)</li> </ul>	Days: Weeks: Months: Years:						
6. Were you ever homeless as a child? □ NO□□ YES							
7. Before you were 18, did you ever live out of your home a	and away from your family? $\square$ NO $\square$ YES						
8. Is there anyone you can contact in an emergency or time Who is that person? Name:							
9. Have you ever been picked up or arrested by the police?	□ NO □ YES						
10. Have you ever spent time in jail, prison or a juvenile de	tention center?   NO  YES						
11. Are you currently suffering from a chronic illness or phy disability?							

 $<sup>^{\</sup>rm 2}$  Developed by the Office of Mental Health – Homeless Action Committee

12. Did you drink or use street drugs in the last 3	<b>30 days?</b> (If No, skip to #13).	□ NO □ YES	
a. What kind of substance did you use?			
b. How often did you use the substance?			
□ Daily	□ Once a	week	
□ Less than once a week	□ 4 <b>–</b> 6 ti	mes a week	
☐ 2 -3 times a week			
c. How much of the substance did you use? _			
13. Did you ever live in or participate in a detox treatment program?	program, a halfway house c	r a residential substance a	buse □ NO □YES
14. Before you were 18, were you ever physicall	y, emotionally or sexually a	bused? □ NO □YES	
15. Have you experienced domestic violence, ab	use or assault in last 30 day	s? □ NO □YES	
16. Have you ever received treatment for an em	otional or psychiatric proble	em? □ NO □YES	
a. When and were you most recently treated	1?		
b. Where did you receive treatment?			
c. Were you prescribed medication for that e			
d. Medication(s) prescribed:			
47.11			
17. Have you ever spent time in a hospital overr	night for an emotional / psyc	chiatric problem? $\square$ NC	) □ YES
RISK OF HOMELESSNESS:			
Total number of boxes checked "YES"			
a. High = 8 + Boxes checked "YES"			
<b>b. Moderate = 3 – 7</b> Boxes checked "YES"			
c. Mild = 1 – 2 Boxes checked "YES"			
Score: Level:			
Do not count question 1 towards the number of	boxes checked "YES." If que	estion checked "YES" client	t is currently homeless.
_			
4. DOMESTIC VIOLENCE (The HITS Scale <sup>3</sup>		ns & Screams Domesti	c Violence))
1. <b>HURT:</b> How often does your partner physically	·-		
$\Box$ 1 = Never $\Box$ 2 = Rarely	□ 3 = Sometimes	☐ 4 = Fairly Often	□ 5 = Frequently
2. INCLUE. How often does your newtoon insult on	2 بروی ماه بروی المط		
2. <b>INSULT:</b> How often does your partner insult or □ <b>1 = Never</b> □ <b>2 = Rarely</b>	□ 3 = Sometimes	☐ 4 = Fairly Often	☐ 5 = Frequently
= 1 - Nevel = 2 - Raiely	_ 3 - 30illetililes	4 - Fairly Often	□ 5 - Frequently
3. <b>THREATEN:</b> How often does your partner threa	aten vou with physical harm	<b>)</b>	
☐ 1 = Never ☐ 2 = Rarely	☐ 3 = Sometimes	☐ 4 = Fairly Often	□ 5 = Frequently
•		•	• •
4. <b>SCREAM:</b> How often does your partner scream	or curse at you?		
$\Box$ 1 = Never $\Box$ 2 = Rarely	☐ 3 = Sometimes	☐ 4 = Fairly Often	□ 5 = Frequently
RISK OF DOMESTIC VIOLENCE: Score ranges from	n 4 to a maximum of 20		
-			
Score: (A score equal to or	r greater than 10 is consider	ed diaanostic of abuse)	

<sup>&</sup>lt;sup>3</sup> Kevin M. Sherin, MD, MPH; James M. Sinacore, PhD; Xiao-Qiang Li, MD; Robert E. Zitter, PhD; Amer Shakil, MD (1998). HITS: A Short Domestic Violence Screening Tool for Use in a Family Practice Setting. *Family Medicine* 30(7):508-12.

5.	W	1	CII	NI /	١т		N	н	יסו	$\Gamma \cap$	D	v
Э.	v	4 L	LII	INA	4 I	w	IV	п	13	ıu	רחי	T

Does client have immunization card with them?	□NO □YES
If client does not have immunization card, can he/she bring it?	□NO □YES (Date:/)
If immunization card is not available, will client sign a release of information in order to obtain vaccination history?	□NO □YES

If client does not have immunization of	ing it? $\square NO \square N$	/ES (Date:/)	
If immunization card is not available, vinformation in order to obtain vaccina	ease of ONO ON	/ES	
<b>6. TRANSPORTATION EVALUATION</b> How do you get to your medical or suppor	t service visits?		
☐ Public transportation		ide from family membe	er or friend
☐ Medicaid taxi	□Ri	ide from program volur	nteer
☐ Taxi (non-Medicaid)	□ <b>w</b>	/alk	
☐ Own vehicle	□ 0	ther	
Do you have difficulty arranging transporta  If yes, why?		o □ Yes	
Note any transportation barriers or concer			
Tell me how you are meeting your nutritio  Obtaining enough nutritious food to  Grocery shopping?   No  Ye  Do you receive or use any of the following	Preparing f Food storag	ood/cooking? □ No □ Yes	
	Food Ass		
Assistance type	Receive/Use?	How often?	From where?
Food stamps	☐ No ☐ Yes		
Food pantry	☐ No ☐ Yes		
Home delivered meals	☐ No ☐ Yes		
Congregate meals	☐ No ☐ Yes		
Food voucher	☐ No ☐ Yes		
Other	☐ No ☐ Yes		
Do you have any dietary limitations or food	d allergies?	☐ No ☐ Yes	
Do you have any problems eating due to m	☐ No ☐ Yes		
Have you ever seen a nutritionist/registere How is your appetite?	ed dietician?	□ No □ Yes	
Do you need any assistance with "activities	s of daily living," e.	g., bathing, dressing an	d bathroom, or eating? $\square$ No $\square$
Do you need assistance with housekeeping	g, shopping, remen	nbering appointments,	or using the telephone? $\ \square$ No $\ \square$
Do you have adequate clothing? $\qed$	No □ Yes	Do you have any ot	her basic needs? ☐ No ☐ Yes
Note any additional nutrition or basic need	ls concerns helow:		

## 8. ADHERENCE ASSESSMENTS<sup>4</sup>

(REALM-R, Medication Knowledge, Readiness Ruler, Duke-UNC FSSQ)

REALM-R (Rapid Estimate of Adult Literacy in Medicine - Revised)							
Fat							
Flu							
Pill							
Allergic							
Jaundice							
Anemia							
Fatigue							
Directed							
Colitis							
Constipation							
Osteoporosis							
Scoring: Fat, Flu, and Pill are not scored. A score of 6	correct or less is used to identify patients at risk for poor literacy.						

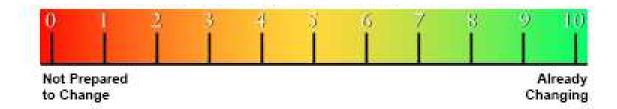
MEDICATION KNOWLEDGE SURVEY										
First column: Filled in by MCM										
Next: Check all boxes patients can answer successfully and fill in the information they provide to you about each of their medications.										
Medication	Name of Medication?	Why are you taking medication?	How much to take each time?	When to take the medication?	Effects to look out for P N		Where do you keep the medication?	When is the next refill? Record date.		
P =	Positive effect	s of taking med	dication, N = Ne	egative effects	of taki	ng me	dication			

<sup>&</sup>lt;sup>4</sup> Case Management Society of America, *Case Management Adherence Guidelines*, 2006.

### Readiness-to-Change Ruler

One the line below, mark where you are now on this line that measures your change in

Are you not prepared to change, somewhere in the middle or already changing?



## **Readiness-to-Change Ruler**

One the line below, mark where you are now on this line that measures your change in

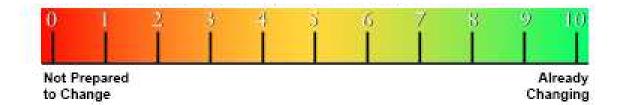
Are you not prepared to change, somewhere in the middle or already changing?



## Readiness-to-Change Ruler

One the line below, mark where you are now on this line that measures your change in

Are you not prepared to change, somewhere in the middle or already changing?



DUKE – UNC FUNCTIONAL SOCIAL SUPPORT QUESTIONNAIRE (FSSQ)										
	5	4	3	2	1					
	As much as I	Almost as much	Some, but	Less than I	Much less than I					
	would like	as I would like	would like more	would like	would like					
I have people who care what happens to me.										
2. I get love and affection.										
I get chances to talk to someone about problems at work or with my housework.										
I get chances to talk to someone I trust about my personal or family problems.										
5. I get chances to talk about money matters.										
6. I get invitations to go out and do things with other people.										
7. I get useful advice about important things in life.										
8. I get help when I am sick in bed.										
	FS	SSQ Scoring Instruct	ions							
1. All questions must be completed	to score the FSSQ.									
2. Add the numeric scores for all 8 c	questions.									
3. Divide the total score by 8 to ach	ieve an average sco	re.								
Scoring: As social support increases	s, the score should i	increase. If the num	ber is low, please a	ddress on the Well	ness Plan.					
Medical Case Manager Signature			Date		_					